*P-IRO Inc.*
*An Independent Review Organization*
*Phone Number:*
**(817) 779-3287**
**1301 E Debbie Lane Suite 102 PMB 203**
**Mansfield, TX 76063**
*Email:p-iro@irosolutions.com*
*Fax Number:*
**(817) 385-9612**

# P-IRO Inc.

## Notice of Independent Review Decision

***Case Number:*** **XXXXXX** ***Date of Notice:*** 02/01/2017

***Review Outcome:***

***A description of the qualifications for each physician or other health care provider who reviewed the decision:***
Orthopaedic Surgery
Sports Medicine

***Description of the service or services in dispute:***
Right soulder arthroscopy, rotator cufrf repair, labrum repair versus debridement and decompression/debridement

***Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:***

- ☐ Upheld (Agree)
- ☑ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

***Patient Clinical History (Summary)***

This case involves a now XX with a history of an occupational claim from XXXX. The mechanism of injury is detailed as XXXXX. The current diagnoses are documented as right shoulder full thickness rotator cuff tear; right shoulder labrum tear with paralabral cyst.

The patient underwent an MRI of the right shoulder on XXXX, which was noted to reveal a complex full thickness tear of the distal rotator cuff at its greater tuberosity insertion/foot print involving the supraspinatus and anterior aspect of the infraspinatus tendons measuring at least 2.1 cm without significant medial retraction; partial thickness bursal surface tear of the remainder of the infraspinatus tendon; mild subscapularis tendinopathy; tear of the posterosuperior glenoid labrum with paralabral cyst measuring 2.1 cm in width by 0.7 cm cranial caudally x 0.9 cm. The tear extended involving the posterior glenoid labrum with additional paralabral cyst. There was tendinopathy of the intra-articular segment of the long head of the biceps tendon; 5 mm loose body suspected within the bicipital groove.

The most recent clinical documentation provided for review dated XXXX indicated that the patient complained of right shoulder pain during the assessment. It was noted that the patient needed to undergo at least 6 weeks of observed and monitored physical therapy with a followup examination. It was noted that the patient complained of persistent pain in the right shoulder with the inability to use his arm for activities of

daily living. The patient reported that he was unable to comfortably sleep on the right side and was losing range of motion. The patient reported no radicular symptoms. The physical examination revealed positive impingement signs. The patient was able to forward flex his right shoulder to about 120 degrees with 90 degrees abduction and 30 degrees external rotation. There was weakness with supraspinatus and infraspinatus testing. There was a positive Speed's and O'Brien's test on examination. The patient was given a prescription for physical therapy and a prescription for Tylenol No. 3 for pain.

***Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.***

The requested right shoulder arthroscopic rotator cuff repair, labrum repair versus debridement and decompression is medically necessary.

Per the Official Disability Guidelines, rotator cuff repair is indicated for shoulder pain with the inability to elevate the arm and tenderness over the greater tuberosity. There must be objective clinical findings of weakness with abduction testing, atrophy of shoulder musculature with positive evidence of deficit in the rotator cuff noted on MRI. The guidelines also specify that surgery for superior labrum anterior and posterior lesions is indicated after 3 months of conservative treatment. Clinical history, physical examination, and imaging studies should indicate high likelihood of a superior labrum anterior and posterior tear. The guidelines specify that type 2 and type 3 lesions do not need any treatment or can be lightly debrided if other arthroscopic shoulder procedures are indicated.

The records indicate that the patient was noted to have a full thickness tear of a rotator cuff at its greater tuberosity insertion involving the supraspinatus and anterior aspect of the infraspinatus tendon; tear of the posterosuperior glenoid labrum that extended to involve the posterior glenoid labrum; tendinopathy of the intra-articular segment of the long head of the biceps tendon. It was noted that the patient reported the inability to use his arms for activities of daily living, report losing range of motion, and the inability to sleep on the right side due to pain. It was noted in the most recent clinical documentation provided for review that the patient was to begin 6 weeks of physical therapy.

Additionally, given the imaging evidence of a full-thickness rotator cuff tear, conservative treatment with physical therapy would not be required, given the type of lesion and need for surgical intervention.

Based on the information provided for review, the requested right shoulder arthroscopic procedure should be overturned.

***A description and the source of the screening criteria or other clinical basis used to make the decision:***

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and Guidelines
- ☐ European Guidelines for Management of Chronic Low Back Pain

***Case Number:*** XXXXXX ***Date of Notice:*** 02/01/2017

- ☐ Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)